**\*ALL FIELDS NEED TO BE COMPLETED\***

**Specialist Prosthetic Referral Form (DSF5/4)**

| **Patient Details (Attach addressograph)**  Name:  Address:  Dob:  Hospital number/NHS number:  Male/Female (Please Circle)  Home telephone number: | **GP Details:**  Name:  Address: |
| --- | --- |
| **Next of kin details:**  Name:  Address:  Telephone number: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Details of amputation** | |  | | |
| Primary cause of amputation: | |  | | |
| History leading up to amputation: | |  | | |
| Level(s) and right/left: | |  | | |
| Operation dates: | |  | | |
| Details of operation: | |  | | |
| Relevant post-operative details: | |  | | |
| Consultant in charge: |  | | Hospital and ward: |  |
| **Contralateral limb details** e.g. circulation, sensation, etc | | |  | |
| **Previous Medical History** e.g. diabetes | | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Podiatry referral?** (Yes/No) |  | |  |
| **Other relevant details** e.g. MRSA status,Latex allergy, Smoking, Alcohol, Other Substances | | | |
|  | | | |
| **Previous Mobility** e.g. independent, stick | | | |
|  | | | |
| **Home environment** e.g. access, stairs | | | |
|  | | | |
| **Current Medications** | | | |
|  | | | |
| **Allergies** | | | |
| **Current wound status** | |  | |
| **Physiotherapy details** (current or planned)  Name and hospital: | |  | |
| **Waterlow Score: Date:** | | | |

|  |  |
| --- | --- |
| **Has the patient ever served in the armed forces?**  **(**Please circle all that apply)    YES NO VETERAN WAR PENSIONER | |
| **Any further comments:** | |
| **Discharge destination:** |  |
| **Details of referrer**  Name: Position:  Bleep number: Hospital:  Signature: Date/Time | |

**Please post or fax the referral form to:**

**Prosthetics Rehabilitation Service, 1 Brest Way, Derriford, Plymouth**

**PL6 5XW.**

**Telephone: 01752 434227**